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ABSTRACT

Contracting, the process of engaging one or both parents in the delivery of psychiatric services to the child, is an essential condition for successful treatment and parental collaboration around management of the emotionally disturbed child. There are three components of the treatment contract: emotional, cognitive, and practical support. Common problems in establishing the contract include the parents' own psychopathology and emotional turbulence and the professonals' own reaction to the perceived negative presentation of parents. Case examples illustrate problems encountered with parents and the factors of the treatment contract. (SB)

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THE TREATMENT CONTRACT WITH PARENTS OF EMOTIONALLY DISTURBED CHILDREN

by

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INTRODUCTION

This paper is about contracts: between parents of emotionally disturbed children who have been referred for psychiatric services, and the mental health professionals who administer the services to the children. Contracting is the process of engaging one or both parents in the delivery of psychiatric services to the child, and is an essential condition for both successful treatment and parental collaboration around management. Oftentimes, parents become labeled as "difficult" by professionals assigned to emotionally disturbed children, and are then overlooked in the treatment efforts. In this paper, the process of engaging parents is defined as the development and implementation of a "Treatment Contract" in which three components of support are identified: Emotional, Cognitive and Practical. The paper will demonstrate how the contract is developed and can be useful especially with "difficult" parents.

The concept of contract has been present in Social Work theory since the 1940s in writings on group work and is a fundamental tenet of Casework in "starting where the client is." Maluccio and Marlow (1974) in their paper called "The Case For the Contract", believe that the contract can be used as a model for service delivery and has the potential to promote meaningful and productive interactions between worker and client, but the concept could be more fully

formulated and incorporated into practice.[1] They contrast Social Work theorists who define contract as the agreement between worker and client following the initial phase of Social Work intervention with that of Menninger, who, from a psychoanalytic perspective, argues that the contract can be used in ongoing psychotherapy between a patient and the therapist.[2] The idea of contracting has been largely utilized in crisis intervention and short term treatment. Braiman, in her paper called "The Establishment of a Therapeutic Alliance with Parents of Psychiatrically Hospitalized Children", suggests that the establishment of a therapeutic alliance with parents is necessary as a pre-condition for successful family-oriented therapy.[3]

Treatment of emotionally disturbed children is especially complex because it means working with two or more sets of clients: the child as the patient, and one or both parents as collaborative assistants. If a child is very disturbed, the parent(s)' participation may be the only access the therapist has for helping the child. The premise of this paper is that contracting is a necessary and ongoing process of helping parents of emotionally disturbed children. This process occurs from the time of the referral throughout the child's treatment. Any or all disciplines of a mental health team can develop and establish the treatment contract with parents. The clinical observations within this paper have been gained in a large municipal hospital where children are seen in separate inpatient and outpatient

services. Case examples will highlight the necessary contracting principles and a preliminary study of discharges Against Medical Advice (AMA) which occurred on the Children's Inpatient Unit will be mentioned.

PARENT REACTIONS TO CHILD'S NEED FOR TREATMENT

When a child's emotional disorder requires professional help and possible hospital admission, most parents experience a series of disquieting feelings such as anxiety, shame, anger, relief and guilt. Such feelings often interfere with the parents' ability to understand explanations and recommendations about their child. Parents' own psychopathology may also present an obstacle in their ability to recognize their child's problem behavior. In addition to these emotional intereferences, some parents have intellectual limitations which may further confound them while trying to understand what is wrong with their child and the rationale of the treatment recommendations.

As the parents try to cope with the stresses related to the needs of their disturbed child, they often use characteristic psychological defenses as denial and minimization of the information and facts given them; they may project self-blame and anger upon others (including the mental health team); they may believe in "magical cures", or compete with the professional workers. These defenses contribute to the parental expectations of the facility which claims an ability to help the child. These expectations (often distorted) at times are perceived as "resistance" by the psychiatric team and the parents labelled as "difficult."

COMPONENTS OF THE TREATMENT CONTRACT

The goal of psychiatric intervention with children is to restore progressively healthy functioning and to alleviate regressive, destructive behavior. To do so, one or both of the parents of the child must be enlisted as a major resource in the child's support. The professional must acknowledge the parent(s)' predominant fears, anxieties and concerns about the child and determine expectations about intervention in order to establish mutual goals for treatment. The parents' expectations may differ widely from those of the mental health professional. Recognition of the parents' upsetting feelings is one of the components of the contract, that is, the provision of Emotional support. Another important component is Cognitive support, that is, helping the parents understand the child's difficulties. Oftentimes this must be done concretely and repeatedly, and for some parents this may be necessary before they can even accept emotional support.

Parents must be educated to the methods and expectations of their participation in their child's treatment such as: to keep regular appointments, to share as much information as possible about family and developmental history, and to provide feedback about their observations of the child's behavior. The third contracting component is Practical support, which includes providing parents with concrete services, initiating referrals to other agencies, and assisting with other family problems.

The treatment contract is thus defined as the ongoing process of helping parents understand their child's problems, clearly spelling out the nature of the treatment, and enlisting parent cooperation. The contract also facilitates parents in becoming active participants in their child's treatment, in order to provide maximum therapeutic services. This process helps to prevent early termination of treatment or hospital discharges against medical advice.

DESCRIPTION OF THE CHILDRENS' PSYCHIATRIC SERVICES

The setting is Bellevue Psychiatric Hospital in New York City, a large municipal hospital with a University Medical School Affiliation. The Childrens' Services consist of an 18 bed Inpatient Unit with a therapeutic nursery and a separate Outpatient Clinic. Children served in both services are from ages 2½ through 11. A major proportion of the children come from severely disorganized and poor families, often with a single parent, and with socio-cultural and environmental problems contributing to their emotional disorders. Referrals to the Childrens' Services come from within the hospital itself and from a variety of outside agencies such as: Child Protective Services, Family Court, other hospitals and school Guidance Counselors.

For the most part, parents bring their children voluntarily, although they may not be the initiators of help. Outside sources may recognize the problem first.

Children admitted to the inpatient service stay for an average of two to three months for a complete evaluation and diagnostic work up. It is essential for parents to agree to

the hospitalization; to sign the child into the hospital voluntarily, and to consent to participation in further programs such as special medical studies and new techniques in medication. In the child outpatient clinic, parents must also sign consent for treatment, and unlike outpatient treatment for many adolescents, most children are dependent upon an adult to accompany them to the clinic to keep the appointments. In both in and outpatient services, parental consent is the first factor of a child's treatment.

COMMON PROBLEMS IN ESTABLISHING THE CONTRACT

As mentioned before, feelings which are commonly shared by parents whose children are recommended for treatment in either inpatient or outpatient services can pose problems or obstacles in beginning and pursuing treatment. Some examples of common problems and the ways parents may cope with them are: 1. Parents' fear of separation from the child may contribute to a sense of isolation or panic in the parents. The parents may defend against these feelings with a hypercritical or abusive attitude towards the treatment team. 2. Parents focus only on their child's problem in order to keep further exposure of the family problem at a minimum. Additionally, as a child begins to improve this may threaten the long established equilibrium in the family, and as in the fear of (which can also be for some, the wish for) separation, parents may withdraw and become increasingly unavailable for appointments. 3. Other common reasons for problems in contracting lie with parents'

limitations in the use and understanding of language, cultural factors such as religious and ethic beliefs, and the cognitive or intellectual capacity to grasp the child's problem. These limitations make it difficult for the family to respect the seriousness of the problem and to accept the rationale for suggested treatment. 4. The parents' own psychopathology and emotional turbulence may interfere in offering emotional and cognitive support. 5. Finally, the most important problem area for professionals is their own reaction (countertransference) to the perceived negative presentation of parents. Parents may be seen as "too limited, crazy, or unmotivated" for the professional to take time to patiently coach and inform the parents about their involvement in the child's treatment.

In our experience, all of the above problems are common contributing factors to the early termination of treatment and discharge from the hospital against medical advice. That is, they represent a non-existent or breakdown of the treatment contract.

CASE EXAMPLES

The following case examples will illustrate problems encountered with parents and the factors of the treatment contract. The examples will also demonstrate the ongoing process of defining mutual goals and clarifying expectations between parents and the mental health team for both inpatient and outpatient services.

Lucy, a 5½ year old Hispanic girl was followed in the Child Outpatient Clinic and hospitalized three times in two years. Originally brought to the outpatient clinic by her

mother for overactive behavior, fighting and aggressiveness with her siblings and classmates, she was evaluated and transferred to a therapist for psychotherapy. After the first outpatient session with Lucy, she had a provocative week-end of fighting with her older siblings at home. Her exasperated mother hit her severely on her face and sent her to school. Child Protective Services was notified and in lieu of emergency shelter, Lucy was admitted to our inpatient service.

During the evaluation in the outpatient clinic, Lucy's mother was described as a taciturn, cold, unhappy woman who spoke very little English. She appeared to defend against her discomfort about Lucy's misconduct with an expectation that the psychiatric intervention would quickly (magically) change her. When Lucy was hospitalized, her mother was given time and encouragement to explain her feelings. Lucy's mother revealed herself to be an intelligent, concerned woman, fluent in English, who had many conflicts about her family and around her ability to set limits with her children. The mother's willingness to discuss her extreme frustration, to accept hospitalization for Lucy, and to keep regular appointments were emphasized by the worker as strengths.

The inpatient team recommended placement for Lucy in a Residential Treatment Center where she could receive strong limits and structure. The mother felt guilty about "rejecting" her daughter and asked to take Lucy home with a

try on medication and regular outpatient appointments. Lucy missed a number of these appointments; her mother, "disillusioned" by the lack of effects of the medication on her behavior, did not renew it. Lucy was again hospitalized to stabilize her medication and for her mother to recontract her expectations about treatment for Lucy. Residential treatment was again recommended, but her mother was still reluctant to place her. Lucy attended outpatient treatment sessions sporadically for another six months and performed somewhat better in school.

The culminating point of humiliation for Lucy's mother came two years after the first evaluation of Lucy, when the school reported an incident of Lucy stealing candy from her teacher and she faced suspension. At home, she had stolen money from her mother, thrown food and money out of the window, and provoked fights with her siblings. This time, Lucy's mother requested placement and interim hospitalization.

If Lucy's mother's feelings of shame and embarrassment had been immediately addressed at the time of the first outpatient evaluation, the mother's assault may have been prevented. Lucy's mother, initially both angry and guilty about Lucy's behavior, presented herself as uncooperative and unlikable to the mental health team. The early assault on Lucy may have also been a result of her mother's acute disappointment and possible realization that psychotherapy was not a magical cure. When Lucy was hospitalized, careful explanation for the need for her mother to be involved

enabled her mother to keep regular appointments and to share detailed history about herself and the family. Lucy's mother's decision to place her in residential treatment was an evolution of redefining mutual goals and clarifying expectations for treatment of Lucy.

Susan, an 11 year old Hispanic girl, was referred for inpatient hospitalization due to suicidal and psychotic ideation. The mother and daughter were initially reluctant for Susan to be hospitalized, but Susan made the "final" decision. It was strongly stated to the pair that the hospital personnel, as the authority, felt Susan must be admitted to protect her from suicidal thoughts. Susan's parents had been separated for 9 years, and she had developed precocious puberty at 8 years of age.

Within the first week of Susan's hospitalization, her mother threatened to kill herself if her daughter was not immediately released. The mother was promptly referred to our psychiatric emergency room, and was eventually seen at another hospital for psychotropic medication which gave symptomatic relief. She also began individual treatment with an Hispanic therapist. Susan's mother became more relaxed and cooperative about her daughter's hospital stay. The decision regarding Susan's length of stay then became a contracting goal. Susan was able to go home on a pass, and she reported improved relations between her mother and herself. This then provided a mutual goal to allow an early discharge since it was Christmas. The mother by now

had become an enthusiastic ally in the hospital's treatment approach. She collected $100 from family and friends to donate to the ward and provided food for the ward's holiday party.

In Susan's case, the potential AMA discharge was avoided due to the mother's decompensated behavior. Contracting focused on pursuing treatment for the mother, acknowledgement of her marked separation problems with her daughter, and allowance for a trial pass home. With the mother's improvement through her own psychotherapy and medication, and the team's assessment that Susan's suicidal ideation was related to her rage towards her mother, the child was permitted an early discharge home.

In contrast to inpatient treatment, most children seen in the outpatient clinic are dependent upon their parents to keep regular appointments. Parents must be enlisted to participate and collaborate with the therapist regarding the management of the child and to share pertinent observations. The parent provides the therapist with valuable information regarding the child's behavior at home while the therapist helps the parent with parenting skills. The parent then acts as assistant therapist.

Calvin, a 10 year old Black boy, was brought to the Child Outpatient Clinic by his mother, who was urged to seek help for him by his private school. In the previous school year, Calvin had stolen money from his teacher and had written grafitti on the wall. In the new school year,

he called a Black classmate "Nigger."

His mother, an upwardly mobile, aspiring woman, worked two jobs to earn money to attain material possessions such as a Cooperative apartment, car, Atari games, and designer sports clothes. Calvin was a good looking, well groomed youngster who had been singled out as a bad boy in his family. It was noted that Calvin resembled his alcoholic father from whom his mother was divorced. She had remarried a professional man and had additional children by him. Calvin's mother reacted to the recommendation for his evaluation and subsequent psychotherapy with quiet rage and embarrassment. She stated she did not see any reason for Calvin's treatment but would go along with the recommendation. The psychiatric Resident treating Calvin told the mother she would have to be involved, but did not establish regular contacts. The mother expressed her upset about the need for Calvin's treatment by being consistently late for appointments which thus potentially frustrated the therapist.

In this case, the mother's feelings of shame and embarrassment had to be addressed in order to engage her in positive and active participation in her son's treatment. She had a need to project blame onto the Caucasian school personnel whom she perceived to single out her child as being in need of help. She herself needed help and support in order to go along with the treatment recommendation.

An empathic explicit statement was made to the mother that the need for treatment for Calvin was especially painful for her, since she worked so hard to provide well for her family. The therapist needed to mobilize her own feelings of compassion for this woman to offset the negative countertransference.

In all cases of in and outpatient treatment, therapists must be aware of the feelings and expectations of parents and should acknowledge these with them as natural.

DISCUSSION AND CONCLUSION

In a complex hospital setting, sound established principles of therapeutic practice are often overlooked by parents' not being routinely included in their childrens' treatment. As a result, this oversight may contribute to some "therapeutic failures" or premature termination of treatment, lack of parental collaboration around the management of the child, and discharges from the hospital against medical advice. Parents must be engaged in their child's treatment. This process of engagement is defined as the "treatment contract." Parents commonly experience distressing feelings when their child needs psychiatric intervention for emotional disturbances. Parental reactions may be interpreted by the psychiatric team as "resistance." Unless these feelings and reactions are addressed by the professional, parents may be excluded from the treatment of the child. In addition to parents' emotional limitations to accepting help, parents may also have intellectual or

cognitive difficulties in understanding the seriousness of the child's problem and the nature of the recommended treatment.

Three components of support are described as necessary conditions for establishing the contract. Emotional support is the acknowledgement of parents' feelings around having an emotionally disturbed child. Cognitive support is the clear education of parents about the child's problem and the nature of the treatment. The third component of support is the Practical provision of concrete services and assistance with other family problems. The case examples from both inpatient and outpatient services illustrate common difficulties that the parents of emotionally disturbed children are faced with in seeking and receiving treatment for their children.

In 1979, the Inpatient Children's Service at our hospital experienced a "mini-epidemic" of children discharged by their parents against medical advice. An attempt was made to study the dynamics of and to determine potential factors contributing to AMA discharges. It was found that certain parent/child combinations were more prevalent. A correlation between excessive closeness (at times of a symbiotic nature) and the crisis of separation through hospitalization was found to be more frequent. In comparison to non AMA mothers, AMA mothers had more violent husbands, were more dependent on their children in general, and refused residential treatment for their children.[4] Another

factor not previously mentioned in this paper, was the child's ability to manipulate a parent in the treatment setting. Since parents are especially vulnerable to feelings of guilt and failure, particularly at the time of hospitalization, the child can easily work on these feelings and successfully convince the parent(s) to discharge them. These children are inevitably back in the hospital at another time with increased difficulties.

A further development of the AMA study is the administration of a questionnaire to parents at the time of the child's admission to the hospital. Questions focus around the parents' understanding of the child's problems, their expectations around the length of stay in the hospital, and the degree to which they go along with the professional's explanation of the child's problem, and need for hospitalization. It is hypothesized that the use of the questionnaire can assist the psychiatric staff and parents in clarifying mutual goals and expectations around the child's treatment, that is, in developing and implementing the contract.

In summary, there have been few studies on factors effecting treatment drop out and outcome with children and their parents. These few have focused primarily on out-patient treatment. This paper suggests that the establishment and implementation of a treatment contract with parents of children with emotional disturbances is a necessary condition

for successful treatment and management of the child in both inpatient and outpatient services. The treatment contract is an ongoing process of helping parents define their expectations while giving Emotional, Cognitive and Practical support, and establishing mutual goals for the psychiatric intervention.

REFERENCES

1. Maluccio, Anthony N., and Marlow, Wilma, 1974. The Case for the Contract. Social Work, 10 (1):28-36.

2. Ibid. Notes from Karl Menninger, Theory of Psychoanalytic Treatment, New York; Harper & Row, 1964, pp 15-42.

3. Braiman, Susan Gettleman, 1977. The Establishment of a Therapeutic Alliance with Parents of Psychiatrically Hospitalized Children. Social Work in Health Care, 3 (1): 19-27.

4. Green, Wayne, Noble, Kathleen, Mattsson, Åke, 1981. Child Psychiatric Discharges Against Medical Advice (unpublished). Presented to the American Academy of Child Psychiatry, Dallas, Texas, October 1981.